Physician and Professional Provider Participation Agreement

Physician and Professional Provider Participation Agreement

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan ("BCBSM") and the undersigned Physician and Professional Provider ("Physician"), licensed in Michigan to provide health care services to Blue Cross Blue Shield Plan members. This AGREEMENT will be effective on the date accepted by BCBSM and will continue indefinitely unless terminated by either party under the terms set forth in Paragraph 19 below. This AGREEMENT fully supersedes the previous participation agreement entitled Participation Physician's Registration and Agreement. Under this AGREEMENT, Physician and BCBSM agree as follows:

1. BCBSM, or its representative, will make payment directly to Physician for covered services. Covered services are medical or health care services, procedures, treatments or supplies listed or limited in Blue Cross Blue Shield Plan member certificates and/or benefit plan descriptions, and rendered by Physician for diagnosis or treatment of disease or injury, based on BCBSM medical necessity criteria, as set forth in Addendum "A."

2. BCBSM will pay Physician for covered services in accordance with the reimbursement methodology set forth in Addendum "B."

3. BCBSM will process Physician's claims submitted in accordance with this AGREEMENT in a timely fashion.

4. BCBSM will furnish to Physician a system and/or method for verification of eligibility and benefit coverages for members. This verification will be furnished as a Physician service and not a guarantee of payment. Physician will make reasonable inquiry into the identity of the patient.

5. BCBSM will, without charge, supply Physician with BCBSM guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for Physician to deliver covered services to members and be paid.

6. BCBSM will maintain the confidentiality of Physician and member information and records, in accordance with applicable federal and state laws and as set forth in Addendum "C."

BCBSM will indemnify and hold Physician harmless from any claims or litigation brought by members asserting breach of the BCBSM Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding Physician information and data, nor from communicating with customers and hospitals regarding aggregated data pertaining to Physician and his/her peer group.

7. BCBSM will establish a Physician and Professional Provider Contract Advisory Committee Process, as set forth in Addendum "D," through which Physicians may offer advice and consultation on administrative matters relating to this AGREEMENT.

8. BCBSM will provide a reconsideration appeal mechanism for Physician, in accordance with Addendum "E," should Physician disagree with any claim adjudication or audit determination.

9. BCBSM and Physician acknowledge that this AGREEMENT does not limit either party from entering into similar agreements with other parties.

10. Physician certifies that all services billed or reported by Physician are performed personally by Physician or under his/her direct and personal supervision and in his/her presence, except as otherwise authorized and communicated by BCBSM, and are submitted in accordance with the terms and conditions of the members' certificates and/or benefit plan descriptions.

11. Except for copays and deductibles specified in members' certificates and/or benefit plan descriptions, Physician will accept BCBSM payment as full payment for covered services and for any "out of panel" service rendered to a Blue Cross Blue Shield Plan PPA enrollee, and agrees not to collect any further payment from any member, except as set forth in Addendum "F."

12. BCBSM represents that Blue Cross Blue Shield Plan members, by contract, have authorized Physician to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. Physician will release patient information and records requested by BCBSM to enable it to process claims and for pre-or post-payment review of medical records and equipment, as related to claims filed.

13. Physician will endeavor to file complete and accurate claims with BCBSM and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum "G."

14. Physician hereby acknowledges that this AGREEMENT constitutes a contract between Physician and BCBSM, that BCBSM is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans ("Association") permitting BCBSM to use the Blue Cross Blue Shield Service Marks in the state of Michigan, and that BCBSM is not contracting as the agent of the Association.

    Physician further acknowledges and agrees that he has not entered into this AGREEMENT based upon representations by any person other than BCBSM

and that no person, entity, or organization other than BCBSM shall be held accountable or liable to Physician for any of BCBSM's obligations to Physician created under this AGREEMENT. This paragraph shall not create any additional obligations whatsoever on the part of BCBSM other than those obligations created under other provisions of this AGREEMENT.

15. Physician agrees that a claim is neither payable by BCBSM nor a member if the claim is not filed with BCBSM within one hundred eighty (180) days of the date of service, except as provided in Addendum "F."

16. Physician agrees to the publication of his/her name, location and specialty to members.

17. Physician will adhere to BCBSM's policies and procedures regarding utilization review and quality assessment, precertification, case management or other programs established or modified by BCBSM, and will maintain records as set forth in BCBSM administrative policy. BCBSM agrees to furnish Physician with necessary information to enable Physician to adhere to BCBSM policy and procedure.

18. Physician agrees that BCBSM may review, photocopy and audit Physician's records as set forth in the attached Audit and Recovery Policy, Addendum "H."

19. Physician understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

20. Either party may terminate this AGREEMENT with or without cause. Without cause termination requires sixty (60) days written prior notice by either party. For cause termination will be subject to BCBSM Departicipation Policy as set forth in Addendum "I" and as hereafter modified by BCBSM.

21. In the event any portion of this AGREEMENT is declared null and void by statute or ruling of a court of record or BCBSM's regulator, the remaining provisions of this AGREEMENT will remain in full force and effect.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

Addenda

A. Medical Necessity Criteria

B. Reimbursement Methodology

C. Confidentiality Policy

D. Physician and Professional Provider Contract Advisory Committee Process

E. Disputes and Appeals

F. Services for Which Physicians May Bill Members

G. Service Reporting and Claims Overpayment Policy

H. Audit and Recovery Policy

I. Departicipation Policy

MEDICAL NECESSITY CRITERIA

Medical Necessity is determined by Physicians[1]. For purposes of payment by BCBSM, Medical Necessity or Medically Necessary means a determination by Physicians for BCBSM based upon criteria and guidelines developed by Physicians[2] for BCBSM, or, in the absence of such criteria and guidelines, based upon physician review, in accordance with accepted medical standards and practices, that the service:

> is accepted as necessary and appropriate for the patient's condition and is not mainly for the convenience of the member or Physician; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

[1] The term Physician includes the following Professional Providers: Medical Doctors, Doctors of Osteopathy, Doctors of Podiatric Medicine, Doctors of Chiropractic and fully Licensed Psychologists
[2] Acting for the appropriate Professional Provider Class and/or medical speciality.

REIMBURSEMENT METHODOLOGY

For each COVERED SERVICE performed, BCBSM will pay the lesser of billed charges or the published maximum screen as set forth in BCBSM's Maximum Payment Schedule. The Maximum Payment Schedule is based on a system of the ranking of relative values of all medical procedures and services. The relative value system and its rankings have been developed by BCBSM with advice and consultation from Michigan physicians. Relative value units ("RVUs") are determined by ranking relative degrees of complexity, time, skill, risk, training and other factors inherent in the provision of medical procedures and services. Values are assigned to each procedure in relation to the comparative value of all other procedures. Relative value units are multiplied by a constant reimbursement factor to determine the BCBSM price per procedure.

The relative values of medical procedures and services are reviewed by BCBSM as a regular business activity. The review is intended to address the addition of new procedures to the procedure coding nomenclature, new technology for existing procedures and changing trends in practice guidelines. BCBSM consults with Michigan physicians with respect to this ongoing review of RVUs.

BCBSM will make the Payment Schedule available to Physicians and members through State and County medical organizations and societies and at other locations throughout the State accessible to Physicians and members. As a result of the ongoing review process for RVUs, the Payment Schedule is subject to periodic revision. BCBSM will distribute revisions to the sources referenced above.

BCBSM will give individual consideration to cases involving complex treatment or unusual clinical circumstances in determining a fee which exceeds the usual reimbursement level. Physician agrees to accept the decision of BCBSM review committees and BCBSM medical consultants with respect to such cases.

In the event of unexpected and unusual delay in payment of claims filed by Physician, not attributable to strike, act of God or war, BCBSM will advance a reasonable sum of money to Physician, to be repaid as a debit against future claims liability, or as otherwise agreed by BCBSM.

BCBSM will review Physician reimbursement at least every 12 months to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for the protection of the privacy of members, and the confidentiality of personal data, personal information, and Physician financial data and information.

BCBSM's Policy sets forth the guidelines conforming to MCLA 550. 1101 et seq which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of members and the confidentiality of personal data."

In adopting this policy, BCBSM acknowledges the rights of its members to know that personal data and personal information acquired by BCBSM will be treated with respect and with reasonable care to ensure confidentiality; to know that it will not be shared with others except for legitimate business purposes or in accordance with a member's specific consent or specific statutory authority.

The term personal data refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a member, which is maintained or stored by a health care corporation.

The term personal information refers to a document or any similar record relative to a member, including an automated or computer accessible record, containing information such as an address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

The term Physician financial data and information refers to a document or other record, limited to automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain Physician financial data and information as confidential.

BCBSM will collect and maintain necessary member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to members will notify members of these routine uses and contain the member's consent to release data for these purposes. These forms will also advise the members of their rights under this policy.

Upon request, a member will be notified regarding the actual release of personal data.

BCBSM will not release member specific personal data except on a legitimate need to know basis or where the member has given specific authorization. Data released with the member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the member executes in writing another prior and specific informed consent authorizing the additional release. Where protected by specific statutory authority, member specific data will not be released without appropriate authorization.

Experience rated and ASC customers and hospitals may obtain personal data and Physician financial data for auditing and other purposes provided that claims of identifiable members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to accounts and facilities will be required to sign third-party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

PHYSICIAN AND PROFESSIONAL PROVIDER CONTRACT ADVISORY COMMITTEE PROCESS

BCBSM will designate one or more committees comprised of representatives of each of the Physician classes subject to this Agreement as Physician and Professional Provider Contract Advisory Committee(s). This Committee or committees will be convened at regular intervals to offer advice and consultation to BCBSM on the following topics, including, but not necessarily limited to:

(a) proposed modifications or amendments to the Agreement;

(b) administrative issues which may arise under the Agreement;

(c) medical necessity criteria and guidelines;

(d) reimbursement issues;

(e) experimental or investigational procedures;

(f) physician supervision of services.

BCBSM will not seek to modify or amend this Agreement without prior notice to and discussion with the Physician and Professional Provider Contract Advisory Committee or committees. BCBSM will not modify Physician reimbursement under this AGREEMENT without prior notice to and discussion with the Physician and Professional Provider Contract Advisory Committee or Committees, except that BCBSM may undertake modifications to relative value assignments on individual procedure codes without discussion under this process.

No contract modification nor amendment will become effective until after 90 days have elapsed from the date of BCBSM notice to Physicians. Nationally imposed changes to the nomenclature and national coding system for procedure codes which result in modifications to the Maximum Payment Schedule will become effective upon notice to Physicians. No other modification to the Maximum Payment Schedule will become effective until after 90 days have elapsed from the date of BCBSM notice to Physicians.

DISPUTES AND APPEALS

Disputes arising under this AGREEMENT may be appealed as follows. This appeals process includes three potential forums for dispute resolution and is intended to resolve disputed matters quickly and inexpensively. Steps One and Two of the appeal process satisfy the administrative rules arising under BCBSM's enabling act, P.A. 350, as well as this Contract Appeal Process. Please note that an election must be made at the conclusion of Step Two (BCBSM's Post-Conference Statement) regarding Binding Arbitration, Insurance Bureau Review or judicial review of the dispute. Once the Physician or Professional Provider (hereinafter "Doctor") elects one of these three methods for final resolution of the dispute, the remaining two remedies and procedures are deemed waived for that particular dispute. The Doctor shall have the right to appoint another person to act as his/her agent or representative in any of the steps of the Contract Appeals Process.

Disputes may be appealed to the Michigan Insurance Bureau or the Courts of this state. Binding arbitration is available for specified types of disputes only. Non-policy disputes may be arbitrated. Non-policy issues that may arise under this Agreement, include by way of example:

- medical necessity determinations;
- claims denials under the pre-existing condition exclusion in members agreements;
- pre-certification program rejections relating to length of stay or appropriateness of treatment setting; and
- audit recovery demands involving requests for repayment of monies related to testing or x-rays unsupported by the documented medical record.

Policy related disputes are not arbitrable. Policy related issues that may arise under this Agreement include by way of example:

- RVU assignments or conversion factors, both of which affect BCBSM's price per procedure.
- Sanctions in cost containment programs such as the failure to obtain a second surgical opinion for a coronary bypass procedure;
- Multiple surgery rules such as the full and half rule;
- Experimental or investigational benefit exclusions;
- Departicipation decisions; and
- Audit methodology such as the use of statistical sampling for audit refund projections.

Contract Appeals Process

A. Step One: Written Complaint

1. After the Doctor has completed BCBSM's normal status inquiry, telephone and written inquiry procedures, the Doctor shall begin the appeals process by submitting a Written Complaint to BCBSM regarding the nature of any unresolved areas of the dispute. This Complaint should be mailed to:

   Blue Cross Blue Shield of Michigan
   Physician's Ombudsman Unit
   Mail Code 2027
   600 E. Lafayette Blvd.
   Detroit, Michigan 48226-2998

2. BCBSM shall, within thirty (30) days, provide in writing a clear, concise and specific explanation of all of the reasons for its action that form the basis of the Doctor's complaint.

B. Step Two: Informal Conference

1. If the Doctor does not agree with BCBSM's explanation, the Doctor shall request, within sixty (60) days of receipt of BCBSM's written explanation, an informal conference by submitting a Notice of Dispute. This Notice should be mailed to:

   Blue Cross Blue Shield of Michigan
   Physician's Ombudsman Unit
   Mail Code 2027
   600 E. Lafayette Blvd.
   Detroit, Michigan 48226-2998

2. Within thirty (30) days from the Doctor's request, BCBSM shall schedule an informal conference. At the request of the Doctor, the conference may be held by telephone.

3. The purpose of the Informal Conference is to discuss in an informal setting, the dispute and explore possible resolution of that dispute. If the dispute involves matters of a medical nature, a BCBSM consulting doctor will participate in the conference. If the dispute is non-medical in nature, other appropriate BCBSM employee(s) will attend.

4. Within ten (10) days following the conclusion of the Informal Conference, BCBSM shall provide all of the following to the Doctor:

   (a) The proposed resolution;

   (b) The facts, with supporting documentation, on which the proposed resolution is based;

(c) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;

(d) A statement explaining the Doctor's right to appeal the matter within thirty (30) days after receipt of BCBSM's written statement; and

(e) A statement describing the status of each claim involved.

C. Step Three: Independent Third Party Determination

Within thirty (30) days after receipt of BCBSM's post conference statement, the Doctor shall have the right to appeal BCBSM's proposed resolution either by submitting a Demand for Arbitration to BCBSM or by submitting a request to the Michigan Insurance Bureau for an Informal Review and Determination. The Doctor shall also have the option of initiating litigation in the appropriate court. The Doctor's election to pursue binding arbitration is a waiver of any and all other remedies or procedures for resolution of the dispute. Similarly, notice of the Doctor's election to pursue Insurance Bureau review or litigation of the dispute waives any right to submit the dispute to binding arbitration under this Agreement.

1. Binding Arbitration

a. The rules for arbitration are attached.

Binding arbitration of the Doctor's dispute is an alternative to judicial review in any appropriate court of law or to administrative review by the Commissioner of Insurance Bureau under Part 4 of 1980 PA 350, MCL 550.1401, et seq.

b. Pursuant to the Physician Contract Arbitration Rules, the parties agree that this is an agreement for statutory arbitration pursuant to MCLA 600.5001 et seq; MSA 27A.5001 et seq and governed by MCR 3.602, and, as such, a judgment of any circuit court may be rendered upon an arbitration award made pursuant to such agreement.

c. The Demand for Arbitration should be mailed to:

Blue Cross Blue Shield of Michigan
Doctor Arbitration
Mail Code 1925
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

2. Insurance Commissioner Review

   a. Alternatively, the Doctor may elect to have the dispute reviewed by the Insurance Commissioner under Part 4 of 1980 PA 350, MCL 550.1401 et seq and the Administrative Rules concerning Procedures for Informal Managerial Level Conferences and Review of the Commissioner of Insurance. The Rules, effective July 31, 1986, are attached.

   b. The Doctor may initiate the Commissioner's Informal Review and Determination of the dispute by submitting a written complaint to the Commissioner, setting forth the substance of the Complaint and the violations of Part 4 of 1980 PA 350. This complaint should by mailed to:

      Commissioner of Insurance
      Michigan Insurance Bureau
      Post Office Box 30220
      Lansing, Michigan 48909

   c. The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Insurance Bureau. Within ten (10) days of the receipt of position papers or the adjournment of the informal meeting, the Insurance Bureau shall issue its Determination.

   d. If dissatisfied with the Insurance Bureau's Determination, either the Doctor or BCBSM may ask the Insurance Commissioner to hear the matter as a Contested case under the Michigan Administrative Procedures Act. A Contested case must be requested in writing within sixty (60) days after the Insurance Bureau's Determination is mailed.

   e. Either the Doctor or BCBSM may appeal the Contested case result to the Ingham County Circuit Court.

D. Judicial Review

The Doctor may choose to have the dispute decided by any appropriate state or federal court as an alternative to binding arbitration, or administrative review, for other claims or issues which are not identical to those raised in the arbitration or administrative proceeding.

Policy Issue Review Process

Issues, questions or concerns on the part of a Doctor arising under this Agreement and relating to BCBSM policy may be pursued by the Doctor as follows:

1. Submit the question, issue or concern in writing to:

   Blue Cross Blue Shield of Michigan
   Physician's Ombudsman Unit
   Mail Code 2027
   600 Lafayette East
   Detroit, Michigan 48226-2998

2. A response will be issued in writing within thirty (30) days of your request.

3. If you are dissatisfied with the response, you may request a review by the BCBSM Medical Director within thirty (30) days of BCBSM's initial response. You will be notified in writing of BCBSM's final response within thirty (30) days of your request.

   This step concludes the BCBSM policy review process. The issue and its disposition will be reported to the Physician Contract Advisory Committee(s) for information purposes.

DEMAND FOR ARBITRATION

BCBSM and the undersigned Doctor agree to submit to arbitration, administered by the designated arbitration association, and pursuant to the attached Physician Contract Arbitration Rules, the following controversy:

(Describe)

_____

_____

_____

_____

_____

It is further agreed that the above controversy will be submitted to a single arbitrator unless otherwise agreed. It is further agreed that BCBSM and Doctor will abide by the terms of this Agreement and the Rules and will abide by and perform any award rendered by the arbitrator(s) and that a judgment of the court having jurisdiction may be entered on the award.

The amount involved in this dispute is $ _____

The remedy sought is _____ .

The following arbitration association is requested:

PROM ☐

American Arbitration Association ☐

It is understood and agreed that BCBSM and Doctor will each pay a 50 percent share of the total cost of the arbitration proceeding, excluding each party's own attorney fees and expenses, which shall remain the responsibility of that party. The costs of arbitration will include filing fees, arbitrator and hearing fees and any expenses associated with the proceedings, except postponement fees which are the responsibility of the party causing the postponement. The filing fee will be submitted by the Doctor along with the Demand for Arbitration. The Doctor's 50 percent cost will be capped at $7,500.00. BCBSM's 50 percent share of the filing fee will be credited to the Doctor's hearing fees and added to BCBSM's share of the hearing fees.

BCBSM
By: _____

_____
Type Name

Dated: _____

Its: _____

PHYSICIAN CONTRACT ARBITRATION RULES

BCBSM and Doctor agree to use the Commercial Arbitration Rules of the American Arbitration Association for arbitration proceedings requested under this Agreement, except as follows:

- The scope of the Award, Rule 43, is limited to payment of the claim or approval of the service, together with any interest payable under the terms of the Agreement

- Assessment of costs and arbitration fees will abide by the following schedule:

Filing Fee:

- Paid initially by Doctor with 50 percent credit towards other costs (BCBSM ultimately responsible for 50 percent of filing fee)

Arbitration Association Charges and Arbitrator's Fees and

- 50 percent Doctor: Up to $7,500 maximum

- 50 percent BCBSM: Plus Doctor's 50 percent share in excess of $7,500

Court Reporter Fee, Postponement Fee, Costs incurred by party enforcing award and Attorney Fees:

- Paid by party requesting the service or causing the postponement

SERVICES FOR WHICH PHYSICIAN MAY BILL MEMBER

Physician may bill member for:

1. noncovered services unless the service has been deemed a noncovered service solely as a result of a determination by a BCBSM physician or professional provider that the service was MEDICALLY UNNECESSARY, in which case Physician assumes full financial responsibility for the denied claims. BCBSM will endeavor to apply like medical specialties to the claims review process. Physician may bill the Member for claims denied as medically unnecessary only as stated in paragraph 2, below;

2. services determined by a BCBSM physician or professional provider to be MEDICALLY UNNECESSARY, where the member acknowledges that BCBSM will not make payment for such services, and the member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;

3. COVERED SERVICES denied by BCBSM as untimely billed, if all of the following requirements are met:

    a. Physician documents that a claim was not submitted to BCBSM within one hundred eighty (180) days of performance of such services because a member failed to provide proper identifying information;

    b. Physician submits a claim to BCBSM for payment consideration within three (3) months after obtaining the necessary information.

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Physician will furnish a report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, license number of reporting physician and such other information as may be required by BCBSM to adjudicate claims.

Physician will use a provider identification code acceptable to BCBSM for billing of covered services.

Physician agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for covered services by requesting information from members, including but not limited to information pertaining to worker's compensation, other group health insurance, third party liability and other coverages. Physician further agrees to identify those members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Physician is aware the patient has primary coverage with another third party payer or entity, Physician agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Physician shall promptly report overpayments to BCBSM discovered by Physician, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Physician or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where Physician appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the arbitration determination, or the last unappealed determination, whichever occurs first. Audit refund recoveries and other overpayment obligations which cannot be fully repaid over the course of one month, will bear interest at the BCBSM prevailing rate, until fully repaid.

AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to the member's medical records or other pertinent records of Physician to verify medical necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Physician for the reasonable copying expense incurred by Physician where Physician copies records requested by BCBSM in connection with BCBSM audit activities.

Physician shall prepare and maintain all appropriate records on all members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to Physicians by BCBSM, any such requirements subsequently developed which are communicated to Physician prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, medical necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered. The Physician Retrospective Profiling System ("PRP") is one component of BCBSM audit policy. Audits may be conducted outside the Program based on review of information and data different from or not available under PRP.

III. Time

BCBSM may conduct on-site audits during Physician's regular business hours. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary as determined by BCBSM under Addendum `A.' BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on medical necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than medical necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for departicipating facility and Physicians under Regular Business. Departicipated Physicians will have claims subjected to Prepayment Utilization Review and processed as non-par with payments directed to the members. Payments to members for services billed by departicipated Physicians will be made at a rate less than the published Payment Schedule amount. BCBSM Departicipation Policy does not apply to Government Business, i.e., Medicare and FEP.

This policy provides for review and recommendation by the Audits and Investigations Subcommittee (AIS).

All BCBSM provider types and sub-specialties within those provider categories are covered under this policy, whether they have a formal participation agreement with BCBSM or participate on a per case basis.

Criteria under which a Physician may be recommended for departicipation include, but are not limited to, Physicians who are determined to be involved in the inappropriate use or billing of services, Physicians who are convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid, or other third party carriers; Physicians who have had their licensure/certification/accreditation suspended or revoked in Michigan; Physicians who refuse access to records for audit purposes; and Physicians who are in violation of local, state or federal regulations, laws, codes, etc. (See DEPARTICIPATION CRITERIA).

Appeal requests must be submitted in writing by an executive representative of the facility, the Physician and/or his/her duly authorized representative.

The AIS will review the recommendation and make a determination regarding departicipation of the Physician. The departicipation is effective upon notice to the Physician. The AIS will receive any subsequent appeal.

The Opinion Review Board (ORB) will hear all provider related departicipation appeals. The ORB determination may be appealed to the Provider Relations Committee (PRC) of the BCBSM Board of Directors.

The PRC hears appeals based only on the facts and findings of previous reviews. The PRC decision is the final level of the appellate process.

DEPARTICIPATION CRITERIA

Criteria under which a Physician or Professional Provider may be recommended for departicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanor involving BCBSM, Medicare, Medicaid, and/or other health care insurers.

2. Termination or suspension of licensure, certification, registration, certificate of need, or accreditation in Michigan.

3. Physicians or Professional Providers who continue to be non-compliant in their reporting after documented notification.

4. Physicians or Professional Providers who, after notification, continue to bill patients for amounts in excess of deductibles and co-insurance.

5. Physicians or Professional Providers who, upon audit, fail to document the necessity of 50% or more of the audited services billed to BCBSM.

6. Physicians or Professional Providers identified as prescribing/dispensing controlled substances for other than therapeutic reasons.

7. Physicians or Professional Providers demonstrating a pattern of billing for services not rendered or not medically necessary.

8. Physicians or Professional Providers refusing access to records which are deemed essential for BCBSM to determine its liability.

9. Physicians or Professional Providers found to be inducing patients to receive services through the use of work slips, prescriptions, or money.

10. Physicians or Professional Providers demonstrating a pattern of reporting excessive acquisition costs, (i.e., falsely representing the actual cost).

11. Physicians or Professional Providers advertising free service, then billing BCBSM additional services which are not medically indicated.

12. Physicians or Professional Providers who have identified refunds in excess of $100,000.00.

13. Physicians or Professional Providers who are in violation of local, state or federal regulations, laws, codes, etc.